VERIFICATION OF LIABILITY COVERAGE
FOR RECIPROCITY DIVERS
DIVING WITH NOAA

Name of reciprocity diver: _____

Name of institution: _____

Name of NOAA unit involved: _____

Dates of dive activities: _____

This is to verify that the above named individual is covered for costs associated with any dive accident or other medical emergency that may occur while participating in diving operations under NOAA auspices.

Note: Please indicate below the type and extent of coverage, including, but not limited to: emergency transportation (e.g., MEDIVAC), hyperbaric or other medical treatment, hospitalization, and compensation for lost wages associated with extended absence due to work-related medical emergencies (e.g., workers' compensation). You may attach additional information, if necessary.

Type & Extent of Coverage	Dates of Coverage

Comments:

_____ _____ _____

Signature of Institutional Representative Title/Position Date